KingCare℠ Benefits at a Glance

Plan Feature	KingCare℠ Gold	KingCare℠ Silver	KingCare℠ Bronze
Provider choice	You may choose any qualified provider, but you receive higher coverage when you use network providers. Reimbursement for out-of-network medical services is based on reasonable and customary (R&C) rates, and reimbursement for out-of-network prescription drug services is based on the rates Express Scripts pays its network pharmacies. You pay amounts in excess of these rates.		
Annual deductible	$300/person; $900/family Deductible amounts applied to charges incurred in the last three months of the calendar year are carried over and applied to the next year's deductible. **The deductible doesn't apply to prescription drugs, preventive care or hearing aids.**	$600/person; $1,800/family Deductible amounts applied to charges incurred in the last three months of the calendar year are carried over and applied to the next year's deductible. **The deductible doesn't apply to prescription drugs, preventive care or hearing aids.**	$800/person; $2,400/family Deductible amounts applied to charges incurred in the last three months of the calendar year are carried over and applied to the next year's deductible. **The deductible doesn't apply to prescription drugs, preventive care or hearing aids.**
Copays	Applicable only to emergency room care and prescription drugs		
After the deductible/copays, the plan pays most covered services at these levels until you reach the annual out-of-pocket maximum	Network: 85% (You pay 15% coinsurance) Out-of-network: 65% (You pay 35% coinsurance) 100% of network rate after applicable copays for prescription drug claims (Deductible doesn't apply)	Network: 75% (You pay 25% coinsurance) Out-of-network: 55% (You pay 45% coinsurance) 100% of network rate after applicable copays for prescription drug claims (Deductible doesn't apply)	Network: 75% (You pay 25% coinsurance) Out-of-network: 55% (You pay 45% coinsurance) 100% of network rate after applicable copays for prescription drug claims (Deductible doesn't apply)
Annual out-of-pocket maximum for medical services	Network: $800/person or $1,600/family, plus deductible Out-of-network: $1,600/person or $3,200/family, plus deductible Doesn't apply to prescriptions	Network: $1,000/ person or $2,000/ family, plus deductible Out-of-network: $1,800/ person or $3,600/ family, plus deductible Doesn't apply to prescriptions	Network: $1,200/ person or $2,400/ family, plus deductible Out-of-network: $2,000/person or $4,000/family, plus deductible Doesn't apply to prescriptions
Annual out-of-pocket maximum for prescription drugs	$1,500/person or $3,000/family		

Plan Feature	KingCare[SM] Gold	KingCare[SM] Silver	KingCare[SM] Bronze
After you reach the out-of-pocket maximum for medical services, most benefits are paid for the rest of the calendar year at this level	Network: 100% Out-of-network: 100% of R&C charges		
Lifetime maximum	$2,000,000	$2,000,000	$2,000,000

Covered Expenses	KingCare[SM] Gold	KingCare[SM] Silver	KingCare[SM] Bronze
Alternative care (including medically necessary acupuncture, hypnotherapy and massage therapy)	Network: 85% Out-of-network: 65% Massage therapy must be prescribed by a physician. A total of 60 covered visits/year (may include any combination of acupuncture, hypnotherapy and/or massage therapy visits)	Network: 75% Out-of-network: 55% Massage therapy must be prescribed by a physician. A total of 60 covered visits/year (may include any combination of acupuncture, hypnotherapy and/or massage therapy visits)	Network: 75% Out-of-network: 55% Massage therapy must be prescribed by a physician. A total of 60 covered visits/year (may include any combination of acupuncture, hypnotherapy and/or massage therapy visits)
Ambulance services	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%
Chemical dependency treatment (requires preauthorization)	Network: 100% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%
Chiropractic care and manipulative therapy (like all services, must be medically necessary)	Network: 85% Out-of-network: 65% Up to 33 visits/year for combined network and out-of-network services Limited to diagnosis and treatment of musculoskeletal disorders	Network: 75% Out-of-network: 55% Up to 33 visits/year for combined network and out-of-network services Limited to diagnosis and treatment of musculoskeletal disorders	Network: 75% Out-of-network: 55% Up to 33 visits/year for combined network and out-of-network services Limited to diagnosis and treatment of musculoskeletal disorders
Diabetes care training	Network: 85% when prescribed by your physician Out-of-network: 65% when prescribed by your physician	Network: 75% when prescribed by your physician Out-of-network: 55% when prescribed by your physician	Network: 75% when prescribed by your physician Out-of-network: 55% when prescribed by your physician
Diabetes supplies (insulin, needles, syringes, lancets, etc.)	Covered under prescription drugs		

Covered Expenses	KingCare℠ Gold	KingCare℠ Silver	KingCare℠ Bronze
Durable medical equipment, prosthetics and orthopedic appliances	Network: 85% Out-of-network: 65% Preauthorization required for expense of $1,000 or more	Network: 75% Out-of-network: 55% Preauthorization required for expense of $1,000 or more	Network: 75% Out-of-network: 55% Preauthorization required for expense of $1,000 or more
Emergency room care (Also see "Urgent Care")	Emergency care, network: 85% after $100 copay/visit (waived if admitted) Emergency care, out-of-network: 85% after $100 copay/visit (waived if admitted) Non-emergency care, network: 65% after $100 copay/visit Non-emergency care, out-of-network: 65% after $100 copay/visit	Emergency care, network: 75% after $100 copay/visit (waived if admitted) Emergency care, out-of-network: 75% after $100 copay/visit (waived if admitted) Non-emergency care, network: 55% after $100 copay/visit Non-emergency care, out-of-network: 55% after $100 copay/visit	Emergency care, network: 75% after $100 copay/visit (waived if admitted) Emergency care, out-of-network: 75% after $100 copay/visit (waived if admitted) Non-emergency care, network: 55% after $100 copay/visit Non-emergency care, out-of-network: 55% after $100 copay/visit
Family planning	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%
Growth hormones	Network: 85% when preauthorized Out-of-network: 65% when preauthorized May also be covered under the prescription drug benefit	Network: 75% when preauthorized Out-of-network: 55% when preauthorized May also be covered under the prescription drug benefit	Network: 75% when preauthorized Out-of-network: 55% when preauthorized May also be covered under the prescription drug benefit
Hearing aids	100%, up to $500 in 36 months for combined network and out-of-network services Deductible doesn't apply		
Home health care	100% when preauthorized, up to 130 visits/year for combined network and out-of-network services		
Hospice care	100% when preauthorized 12-month lifetime maximum 120-hour maximum for respite care in any 3-month period 12-month maximum for bereavement services		
Hospital care	Network: 85% when preauthorized Out-of-network: 65% when preauthorized	Network: 75% when preauthorized Out-of-network: 55% when preauthorized	Network: 75% when preauthorized Out-of-network: 55% when preauthorized

Covered Expenses	KingCare[SM] Gold	KingCare[SM] Silver	KingCare[SM] Bronze
Infertility	Network: 85% Out-of-network: 65% Limited to specific services and $25,000 lifetime maximum for combined network and out-of-network services	Network: 75% Out-of-network: 55% Limited to specific services and $25,000 lifetime maximum for combined network and out-of-network services	Network: 75% Out-of-network: 55% Limited to specific services and $25,000 lifetime maximum for combined network and out-of-network services
Injury to teeth	Network: 85% Out-of-network: 65% Up to $600/accident for combined network and out-of-network services	Network: 75% Out-of-network: 55% Up to $600/accident for combined network and out-of-network services	Network: 75% Out-of-network: 55% Up to $600/accident for combined network and out-of-network services
Inpatient care alternatives	Network: 85% when preauthorized Out-of-network: 65% when preauthorized	Network: 75% when preauthorized Out-of-network: 55% when preauthorized	Network: 75% when preauthorized Out-of-network: 55% when preauthorized
Jaw abnormalities, or malocclusions (covered when medically necessary)	Network: 85% when preauthorized Out-of-network: 65% when preauthorized	Network: 75% when preauthorized Out-of-network: 55% when preauthorized	Network: 75% when preauthorized Out-of-network: 55% when preauthorized
Lab, X-ray and other diagnostic testing	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%
Maternity care	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%
Mental health care (requires preauthorization)	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%
Naturopathy	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%
Neurodevelopmental therapy for covered dependents age 6 and under	Network: 85% when preauthorized Out-of-network: 65% when preauthorized Up to $2,000/year for combined network and out-of-network services	Network: 75% when preauthorized Out-of-network: 55% when preauthorized Up to $2,000/year for combined network and out-of-network services	Network: 75% when preauthorized Out-of-network: 55% when preauthorized Up to $2,000/year for combined network and out-of-network services

Covered Expenses	KingCare℠ Gold	KingCare℠ Silver	KingCare℠ Bronze
Obesity surgery or other procedures, treatment or services, such as gastric intestinal bypass surgery	Network: 85% when preauthorized and medically necessary Out-of-network: 65% when preauthorized and medically necessary Successful completion of a physician-supervised weight management and exercise program required before preauthorization	Network: 75% when preauthorized and medically necessary Out-of-network: 55% when preauthorized and medically necessary Successful completion of a physician-supervised weight management and exercise program required before preauthorization	Network: 75% when preauthorized and medically necessary Out-of-network: 55% when preauthorized and medically necessary Successful completion of a physician-supervised weight management and exercise program required before preauthorization
Out-of-area coverage—for example, while traveling or for your covered children away at school	Same coverage as when home, through Aetna and Express Scripts national provider networks		
Phenylketonuria (PKU) formula	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%
Physician and other medical/surgical services	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%
Prescription drugs—Up to a 30-day supply through network pharmacies	Generic: 100% after $7 copay Preferred brand: 100% after $30 copay (if a generic is available and your physician certifies you're unable to take it for medical reasons, you only pay a $22 copay) Non-preferred brand: 100% after $60 copay (if a generic is available and your physician certifies you're unable to take it for medical reasons, you only pay a $45 copay) Prescriptions filled at out-of-network pharmacies are reimbursed at the rate Express Scripts pays to network pharmacies, less your copay.		
Prescription drugs—Up to a 90-day supply through mail-order network only	Generic: 100% after $14 copay Preferred brand: 100% after $60 copay (if a generic is available and your physician certifies you're unable to take it for medical reasons, you only pay a $44 copay) Non-preferred brand: 100% after $120 copay (if a generic is available and your physician certifies you're unable to take it for medical reasons, you only pay a $90 copay)		
Preventive care (well-child check-ups, immunizations, routine health and hearing exams, etc.)	Network: 100% Out-of-network: 65% Deductible doesn't apply	Network: 100% Out-of-network: 55% Deductible doesn't apply	Network: 100% Out-of-network: 55% Deductible doesn't apply
Radiation therapy, chemotherapy and respiratory therapy	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%

Covered Expenses	KingCare℠ Gold	KingCare℠ Silver	KingCare℠ Bronze
Reconstructive services (includes benefits for mastectomy-related services; reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema)—Call plan for more information.	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%
Rehabilitative services—Inpatient and outpatient	Network: 85% Out-of-network: 65% *Inpatient:* Up to 60 days/year *Outpatient:* Up to 60 visits/all therapies combined (progress review every 20 visits for out-of-network outpatient)	Network: 75% Out-of-network: 55% *Inpatient:* Up to 60 days/year *Outpatient:* Up to 60 visits/all therapies combined (progress review every 20 visits for out-of-network outpatient)	Network: 75% Out-of-network: 55% *Inpatient:* Up to 60 days/year *Outpatient:* Up to 60 visits/all therapies combined (progress review every 20 visits for out-of-network outpatient)
Skilled nursing facility	Network: 85% when preauthorized Out-of-network: 65% when preauthorized	Network: 75% when preauthorized Out-of-network: 55% when preauthorized	Network: 75% when preauthorized Out-of-network: 55% when preauthorized
Smoking cessation	Network: 100% Out-of-network: 65% Prescription drugs to ease nicotine withdrawal, inhalers and sprays are covered by Express Scripts at 100% (no copay); non-prescription nicotine patches, lozenges and gum are covered by Aetna at 100%.	Network: 100% Out-of-network: 55% Prescription drugs to ease nicotine withdrawal, inhalers and sprays are covered by Express Scripts at 100% (no copay); non-prescription nicotine patches, lozenges and gum are covered by Aetna at 100%.	Network: 100% Out-of-network: 55% Prescription drugs to ease nicotine withdrawal, inhalers and sprays are covered by Express Scripts at 100% (no copay); non-prescription nicotine patches, lozenges and gum are covered by Aetna at 100%.
Temporomandibular joint (TMJ) disorders	Network: 85% when preauthorized Out-of-network: 65% when preauthorized Night guards are covered if prescribed by a medical doctor for a TMJ disorder. Up to $2,000/year for combined network and out-of-network services	Network: 75% when preauthorized Out-of-network: 55% when preauthorized Night guards are covered if prescribed by a medical doctor for a TMJ disorder. Up to $2,000/year for combined network and out-of-network services	Network: 75% when preauthorized Out-of-network: 55% when preauthorized Night guards are covered if prescribed by a medical doctor for a TMJ disorder. Up to $2,000/year for combined network and out-of-network services

Covered Expenses	KingCare℠ Gold	KingCare℠ Silver	KingCare℠ Bronze
Transplants (certain services only)	Network: 100% when preauthorized Out-of-network: 65% when preauthorized Medical coverage must have been continuous for more than 12 months under KingCare℠ before a transplant will be covered.	Network: 100% when preauthorized Out-of-network: 55% when preauthorized Medical coverage must have been continuous for more than 12 months under KingCare℠ before a transplant will be covered.	Network: 100% when preauthorized Out-of-network: 55% when preauthorized Medical coverage must have been continuous for more than 12 months under KingCare℠ before a transplant will be covered.
Urgent care (ear infections, high fevers, minor burns, etc.)	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%

Group Health

Plan Feature	Group Health Gold	Group Health Silver	Group Health Bronze
Provider choice	You choose a Group Health primary care physician (PCP), who provides and coordinates most of your care through the Group Health network; you may also self-refer to Group Health staff specialists. There's no coverage for out-of-network care unless indicated and approved/referred.		
Annual deductible	None		
Copay, unless otherwise indicated	You pay $20	You pay $35	You pay $50
After copays, the plan pays most covered services at these levels until you reach the annual out-of-pocket maximum	Network: 100% Out-of-network: Limited emergency/out-of-area care		
Annual out-of-pocket maximum	Network: $1,000/ person or $2,000/ family Out-of-network: Limited emergency/out-of-area care	Network: $2,000/ person or $4,000/ family Out-of-network: Limited emergency/out-of-area care	Network: $3,000/ person or $6,000/ family Out-of-network: Limited emergency/out-of-area care
After you reach the annual out-of-pocket maximum, most benefits are paid for the rest of the calendar year at this level	Network only: 100%		
Lifetime maximum	No limit		

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
Alternative care (including medically necessary acupuncture, massage therapy and naturopathy)	Self-referrals to a network provider: $20 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy, except for chiropractic services All other alternative care requires PCP referral.	Self-referrals to a network provider: $35 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy, except for chiropractic services All other alternative care requires PCP referral.	Self-referrals to a network provider: $50 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy, except for chiropractic services All other alternative care requires PCP referral.
Ambulance services	80% (except hospital-to-hospital ground transfers, which are covered at 100% when initiated by Group Health)		

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
Chemical dependency treatment (requires preauthorization)	*For inpatient care:* 100% after $200 copay/admission *For outpatient care:* 100% after $20 copay/visit Up to $14,500 in 24 consecutive months (maximum subject to annual adjustment)	*For inpatient care:* 100% after $400 copay/admission *For outpatient care:* 100% after $35 copay/visit Up to $14,500 in 24 consecutive months (maximum subject to annual adjustment)	*For inpatient care:* 100% after $600 copay/admission *For outpatient care:* 100% after $50 copay/visit Up to $14,500 in 24 consecutive months (maximum subject to annual adjustment)
Chiropractic care and manipulative therapy (like all services, must be medically necessary)	100% after $20 copay/visit	100% after $35 copay/visit	100% after $50 copay/visit
Diabetes care training	100% after $20 copay/visit	100% after $35 copay/visit	100% after $50 copay/visit
Diabetes supplies (insulin, needles, syringes, lancets, etc.)	Covered under prescription drugs	Covered under prescription drugs	Covered under prescription drugs
Durable medical equipment, prosthetics and orthopedic appliances	80% when preauthorized	50% when preauthorized	50% when preauthorized
Emergency room care	Network: 100% after $100 copay/visit ($100 copay is waived, but $200 copay/admission for hospital care applies if admitted) Out-of-network: 100% of reasonable and customary expenses after $150 copay/visit ($150 copay is waived but $200 copay/admission for hospital care applies if admitted) **Non-emergency care is not covered.**	Network: 100% after $100 copay/visit ($100 copay is waived, but $400 copay/admission for hospital care applies if admitted) Out-of-network: 100% of reasonable and customary expenses after $150 copay/visit ($150 copay is waived, but $400 copay/admission for hospital care applies if admitted) **Non-emergency care is not covered.**	Network: 100% after $100 copay/visit ($100 copay is waived, but $600 copay/admission for hospital care applies if admitted) Out-of-network: 100% of reasonable and customary expenses after $150 copay/visit ($150 copay is waived, but $600 copay/admission for hospital care applies if admitted) **Non-emergency care is not covered.**
Family planning	100% after $20 copay/visit **Infertility treatment is not covered.**	100% after $35 copay/visit **Infertility treatment is not covered.**	100% after $50 copay/visit **Infertility treatment is not covered.**
Growth hormones	Covered under prescription drugs if medical coverage has been continuous for more than 12 months under this plan whether or not the growth disorder existed before plan coverage		
Hearing aids	100%, up to $300/ear in 36 months		
Home health care	100%		

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
Hospice care	100% when preauthorized Certain limits apply; call plan for details.		
Hospital care	100% after $200 copay/admission	100% after $400 copay/admission	100% after $600 copay/admission
Inpatient care alternatives	100% when preauthorized		
Lab, X-ray and other diagnostic testing	100%		
Maternity care	*For delivery and related hospital care:* 100% after $200 copay/admission *For prenatal and postpartum care:* 100% after $20 copay/visit	*For delivery and related hospital care:* 100% after $400 copay/admission *For prenatal and postpartum care:* 100% after $35 copay/visit	*For delivery and related hospital care:* 100% after $800 copay/admission *For prenatal and postpartum care:* 100% after $50 copay/visit
Mental health care (when deemed appropriate, 2 unused outpatient visits may be traded for 1 inpatient day, or vice versa; requires preauthorization)	*For inpatient care:* 100% after $200 copay per admission, up to 12 days/year *For outpatient care:* 100% after $20 copay/individual, family, couple or group session, up to 20 visits/year	*For inpatient care:* 100% after $400 copay per admission, up to 12 days/year *For outpatient care:* 100% after $35 copay/individual, family, couple or group session, up to 20 visits/year	*For inpatient care:* 100% after $600 copay per admission, up to 12 days/year *For outpatient care:* 100% after $50 copay/individual, family, couple or group session, up to 20 visits/year
Neurodevelopmental therapy for covered dependents age 6 and under	*For inpatient care:* 100% after $200 copay/admission, up to 60 days/year (combined with rehabilitative services) *For outpatient care:* 100% after $20 copay/visit, up to 60 visits/year (combined with rehabilitative services)	*For inpatient care:* 100% after $400 copay/admission, up to 60 days/year (combined with rehabilitative services) *For outpatient care:* 100% after $35 copay/visit, up to 60 visits/year (combined with rehabilitative services)	*For inpatient care:* 100% after $600 copay/admission, up to 60 days/year (combined with rehabilitative services) *For outpatient care:* 100% after $50 copay/visit, up to 60 visits/year (combined with rehabilitative services)
Out-of-area coverage—for example, while traveling or for your covered children away at school	Reciprocal benefits are available through Kaiser Permanente and affiliated HMOs; otherwise, only emergency services are covered out of area.		
Phenylketonuria (PKU) formula	100%		
Physician and other medical/surgical services	*For inpatient care:* 100% *For outpatient care:* 100% after $20 copay/office visit	*For inpatient care:* 100% *For outpatient care:* 100% after $35 copay/office visit	*For inpatient care:* 100% *For outpatient care:* 100% after $50 copay/office visit

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
Prescription drugs—Up to a 30-day supply through network pharmacies	Generic: 100% after $10 copay Preferred brand: 100% after $20 copay Non-preferred brand: 100% after $30 copay Growth hormones: 100% There's no reimbursement for prescriptions filled at out-of-network or out-of-area pharmacies.		
Prescription drug—Up to a 90-day supply through mail-order network only	Generic: 100% after $20 copay Preferred brand: 100% after $40 copay Non-preferred brand: 100% after $60 copay		
Preventive care (well-child check-ups, immunizations, routine health and hearing exams. etc.)	100% (according to well-child/adult preventive schedule)	100% (according to well-child/adult preventive schedule)	100% (according to well-child/adult preventive schedule)
Radiation therapy, chemotherapy and respiratory therapy	100% after $20 copay/visit	100% after $35 copay/visit	100% after $50 copay/visit
Reconstructive services (includes benefits for mastectomy-related services; reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema)—Call plan for more information.	100% depending on services provided; copays may apply (including $200 copay/admission if hospital care is required)	100% depending on services provided; copays may apply (including $400 copay/admission if hospital care is required)	100% depending on services provided; copays may apply (including $600 copay/admission if hospital care is required)
Rehabilitative services—Inpatient and outpatient	*For inpatient care:* 100% after $200 copay/admission, up to 60 days/calendar year (combined with neurodevelopmental therapy) *For outpatient care:* 100% after $20 copay/visit, up to 60 visits/calendar year (combined with neurodevelopmental therapy)	*For inpatient care:* 100% after $400 copay/admission, up to 60 days/calendar year (combined with neurodevelopmental therapy) *For outpatient care:* 100% after $35 copay/visit, up to 60 visits/calendar year (combined with neurodevelopmental therapy)	*For inpatient care:* 100% after $600 copay/admission, up to 60 days/calendar year (combined with neurodevelopmental therapy) *For outpatient care:* 100% after $50 copay/visit, up to 60 visits/calendar year (combined with neurodevelopmental therapy)
Skilled nursing facility	100% up to 60 days/calendar year at a Group Health-approved nursing facility		

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
Smoking cessation	100% for nicotine replacement therapy (including gum, patches or prescription medication) through the Group Health-designated tobacco cessation program, Free & Clear® Quit for Life™ Program, when prescribed by Group Health PCP No annual or lifetime limit		
Temporomandibular joint (TMJ) disorders	*For inpatient care:* 100% after $200 copay/admission *For outpatient care:* 100% after $20 copay/visit Up to $1,000/calendar year and a $5,000 lifetime maximum	*For inpatient care:* 100% after $400 copay/admission *For outpatient care:* 100% after $35 copay/visit Up to $1,000/calendar year and a $5,000 lifetime maximum	*For inpatient care:* 100% after $600 copay/admission *For outpatient care:* 100% after $50 copay/visit Up to $1,000/calendar year and a $5,000 lifetime maximum
Transplants (certain services only)	100% after applicable copays Medical coverage must have been continuous for more than 12 months under this plan before a transplant will be covered.		
Urgent care (ear infections, high fevers, minor burns)	100% after $20 copay/visit	100% after $35 copay/visit	100% after $50 copay/visit
Vision exams	100% after $20 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)	100% after $35 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)	100% after $50 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)